

Health Care Coverage Worksheet

This chart may be used to compare policies. This comparison is not intended to be a complete analysis of the plan's benefits. The master contract provides a detailed description of the policy benefits. Please check your own policy for variations and further details.

Plan Name				
Premium	monthly annual			
Annual Deductible	single family			
Annual Out-of-Pocket Limit				
Coinsurance Percentage				
Preventive Care				
• Immunizations				
• Adult Routine Medical Exams				
• Well Child Examinations				
• Mammograms				
Hospital Services*				
• Room & Board, Misc. Hospital Expenses, & Intensive Care Unit				
• Outpatient Facility Fees				
• Outpatient Radiology, Pathology, and Lab Services				
Emergency Services				
• Emergency Room Care (including Physician Charges and Misc. Expenses)				
• Emergency Room Facility Fees				
• Ambulance				
Professional Services				
• Office Visits				
• Chiropractic Visits				
• Maternity Services				
• Medical Supplies, and Durable Medical Equipment				
• Occupational, Physical, & Speech Therapy				
• Oral Surgery and Dental Repair (due to an injury)				

* Some services may require precertification or prior approval. Financial penalties could apply if an approved precertification or prior approval is not in place for services received.

Professional Services (continued)				
<ul style="list-style-type: none"> Independent Anesthesiologist, Pathologist, and Radiologist Services 				
<ul style="list-style-type: none"> X-Ray and Lab Services 				
Home Health Care				
<ul style="list-style-type: none"> Home Health Service 				
Health Care Services				
<ul style="list-style-type: none"> Breast Reconstruction (following a covered mastectomy) 				
<ul style="list-style-type: none"> Diabetic Equipment, Supplies, and Self-Management Education Programs 				
<ul style="list-style-type: none"> Temporomandibular Joint (TMJ) Disorders 				
<ul style="list-style-type: none"> Skilled Nursing Care 				
Transplants (prior approval may be required)				
<ul style="list-style-type: none"> Heart 				
<ul style="list-style-type: none"> Heart/Lung 				
<ul style="list-style-type: none"> Cornea 				
<ul style="list-style-type: none"> Bone Marrow 				
<ul style="list-style-type: none"> Liver 				
<ul style="list-style-type: none"> Pancreas 				
<ul style="list-style-type: none"> Kidney 				
Alcoholism, Drug Abuse, and Nervous or Mental Disorders				
<ul style="list-style-type: none"> Inpatient 				
<ul style="list-style-type: none"> Outpatient 				
<ul style="list-style-type: none"> Transitional 				
Prescription Drug Coverage				
Out of Area Coverage				
Additional Benefits				
<ul style="list-style-type: none"> Preventive Dental Care 				
<ul style="list-style-type: none"> Vision Exams 				
<ul style="list-style-type: none"> Hearing Exams 				
<ul style="list-style-type: none"> Other 				
Exclusions**				

** The Exclusions section lists the services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the Plan Benefits), or have some limitations on the benefit provided. Some of the listed exclusions may be medically necessary, but still are not covered under the plan, while others may be examples of services which are not medically necessary or not medical in nature, as determined by the Plan.